HEADQUARTERS
EUROPEAN THEATER OF OPERATIONS
UNITED STATES ARMY
Office of the Chief Surgeon
APO 887

Ch Surg 730 x 383.6 5 May 1945

CIRCULAR LETTER NO. 39

SECTION I. CARE OF HAND INJURIES

1. Introductory:

a. Experience in civilian and military fields directs that the early closure of injuries to hands is essential to recovery of good function. The great vascularity of the hand, as in the face, makes closure of such wounds desirable.

b. In the rear areas careful studies on improving the surgical care of the hand in hospitals specially equipped for this field of surgical treatment have revealed that further progress will only occur when improvement is made in the initial therapy. The following instructions are guides for the early surgical treatment of hand injuries.

(1) Surgical Procedure:

(a) Thorough cleansing of entire hand and nails is essential. Nails must be clipped.

(b) Debridement will be meticulous, including removal of all accessible foreign bodies. Skin must be conserved. Tendons may be sutured where loss of substance is minimal.

(c) Primary closure is to be performed. Sutures will be widely spaced. Drains are not to be inserted. Where closure by suture without tension is impossible, split thickness skin grafts will be applied immediately.

(d) Amputations: Conservatism will rule. Amputate only fingers that are irretrievably lost. To aid in closing the remainder of the hand, save the skin of such a finger if it is viable. Wherever possible, the thumb or any part of it will be saved. The 4th and 5th fingers can be most readily spared. A stiff 4th finger jeopardizes the use of the remaining fingers. These amputations will be loosely closed primarily.

(2) Dressings:

(a) Dressings will be snug but not tight. They will adequately cover the entire area.

(b) Immobilization: Hand will be supported on a moulded anterior plaster splint with the hand and fingers in the position of function, i.e. the wrist in slight dorsiflexion, the fingers flexed approximately thirty to forty degrees at all joints, the thumb adducted and slightly flexed.

(c) The hand must now be kept in an elevated position to prevent edema which will drastically interfere with subsequent function of the hand and fingers.

(3) After Care: The wound will be inspected only if local or generalized signs or symptoms of sepsis appear. If there is evidence of infection, remove a sufficient number of sutures to permit drainage. Do not insert drains. Apply heat (dry heat preferable) and continue elevation. Force penicillin therapy.

2. Evacuation Policy: To carry out this primary closure of wounds of the hand, these cases must be held as non-evacuable for a minimum of five (5) days.

SECTION II. PROFESSIONAL POLICIES IN THE CARE OF POW's

1. Adherence to the basic principles of ETO policies of professional management in the care of sick or wounded enemy prisoners is desirable. Where POW's are cared for by US Army personnel, ETO professional policies will be adhered to except as noted below. Where POW's are cared for by protected prisoner personnel, greater latitude will be granted and the POW medical personnel may practice their methods of therapy unless such are found to be contrary to reasonable medical care.

2. The Manual of Therapy, European Theater of Operations, and Circular Letters Nos. 71, 15 May 1944; 101, 30 July 1944; 131, 8 November 1944; and Circular Letter No. 23, 17 March 1945, will be made available to German medical officers as guides for treatment.

3. The Commanding Officers of hospitals utilizing protected prisoner medical personnel will instruct German medical officers that skeletal traction in the treatment of long bone fractures, and closure of wounds by suture and/or skin graft is the treatment to be followed. In the hands of US Army medical officers, this treatment reduced the period of hospital treatment and subsequent disability.

4. Treatment of fractures.

a. Equipment for the treatment of long bone fractures by skeletal traction will be furnished German medical officers who are capable of using it. Steinman pins or Kirschner wires may be employed. External fixation splints such as the Roger Anderson, Haines or Stoder types will not be distributed to German surgeons.

b. When skeletal traction is not employed in the management of compound fractures of long bones, treatment will be by means of circular plaster of paris splints. If wounds are not closed by delayed primary suture, the Orr-Trueta technique will be employed. Healing ordinarily takes place in time.

c. Internal fixation of simple and of compound fractures after the wounds have healed will be performed only after approval by a US Army medical officer.

5. Abdominal surgery, including closure of colostomies, when performed by German surgeons will adhere to methods with which the individual surgeon is familiar.

6. Neuro-surgical, thoraco-surgical or complicated plastic surgical procedures: When no German medical officer capable of doing these types of surgery is available, German POW's will be transferred to a designated special facility for such surgery.

7. Penicillin therapy in POW's:

a. The only indications for the administration of penicillin to POW patients will be the saving of life or limb.

b. Penicillin will not be used in the treatment of venereal disease.

c. Penicillin will not be issued to protected enemy personnel. It will be kept under the control of US Personnel. The Commanding Officer of the hospital concerned must approve the use and dosage of penicillin recommended in every instance where it is prescribed.

By order of the Chief Surgeon:

H. W. DOAN,
Colonel, Medical Corps,
Executive Officer.